

# PUBLIC HEALTH

LONDON: THE SOCIETY OF MEDICAL OFFICERS OF HEALTH  
Tavistock House South, Tavistock Square, W.C.1



No. 12.-Vol. LXIII. MONTHLY PRICE 2s. 6d. ANNUAL SUBSCRIPTION 31s. 6d. SEPTEMBER-1950



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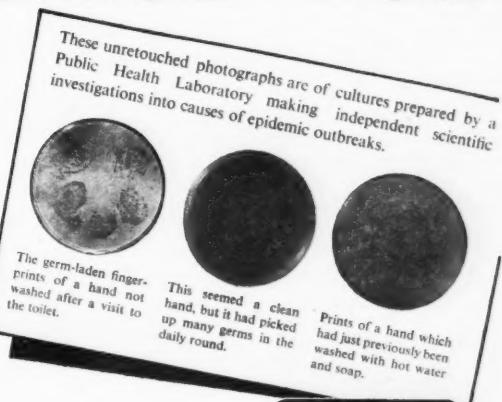


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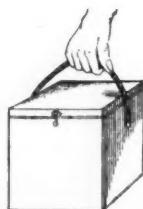
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No. 12, Vol. LXIII

SEPTEMBER, 1950

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*The production of Public Health has been delayed for several months owing to a dispute between the London Master Printers' Federation and the London Society of Compositors. This dispute recently came to a head and the present issue of this journal is seriously under-weight. We apologise for the deferred publication of much material and hope that normal working will soon be resumed.—Editor, Public Health.*

## EDITORIAL

### Arbitration on Salaries

As briefly announced in the weekly medical Press of August 5th the gap between the ideas of the Management and Staff sides of the Medical Whitley Committee C as to what public health salary rates should be was too wide to be bridged by negotiation, and the failure to agree was then reported to the Minister of Labour with the request that the matter be referred to the Industrial Court for arbitration under the Industrial Courts Act, 1919. The terms of reference which have been agreed by both sides are:—

"To determine a difference between the Management and Staff Sides of Committee 'C' of the Medical Council of the Whitley Councils for the Health Services (Great Britain) arising out of the Staff Side's proposals for revised salary scales and conditions of service for medical officers employed by local authorities."

The date of the hearing in the Industrial Court has now been announced as October 9th. Naturally enough, the Public Health Service is anxious to know its future prospects. But there is an encouraging recent precedent in the Court's award on the dispute referred by the Nurses' and Midwives' Whitley Council about the salaries of public health nurses and midwives. Other encouraging facts are the Chancellor of the Exchequer's decision partly to implement the Chorley awards to senior civil servants next year, the increases in pay of the Armed Forces, and the signs of gradual thaw in the industrial field. We know that the case for the Public Health Service is strong and urgent, and that the rest of the medical profession is in sympathy with us.

### Can Rheumatic Infection be Prevented?

In the Section of Epidemiology and State Medicine of the Royal Society of Medicine, Dr. W. H. Bradley took the subject of "The Mechanism and Prevention of the Rheumatic States" for his presidential address.\* Dr. Bradley has undertaken

research in this country and in the United States of America into the aetiology of this crippling disease. The mechanism whereby acute rheumatism occurs in an individual remains a matter of hypothesis; various theories have been put forward over the years but none has fully satisfied the pathology and manifestations of the disease. The occurrence of familial incidence is well known and Bradley suggests that in the mechanism of infection a "genetic factor" may play a part as well as a "factor of infection." For many years controversy has ranged round the labelling of a particular organism which can be definitely associated with rheumatic fever; *Streptococcus pyogenes*, on the evidence accumulated to-day, remains the organism of choice. The relationship between the incidence of scarlet fever and rheumatic fever appears to be established. The incidence of acute nephritis, another disease whose aetiology is not settled and which many consider to be an "allergic" reaction to streptococcal infection, has recently been shown to bear a relationship to the incidence of scarlet fever and rheumatic fever.

Bradley considers that for practical purposes concerning the mechanism of the rheumatic state, scarlet fever and streptococcal sore throats are manifestations of one disease precipitating the rheumatic state. Studies of the appearance of pallor, changes in the blood sedimentation rates and the plasma protein have led him to conclude that if rheumatism is an infective condition then the globulinaemia observed and taken as an indication of antibody response should persist and rise during the illness; this was not the case. He considers that the high globulin level was not merely an effect but might play a causal role in producing the abnormalities we call rheumatism. When acute *Str. pyogenes* infection occurred it was followed by a lag period and by the time the rheumatic process was active, this infection was no more than a remote cause and a new mechanism almost certainly involving an inherited factor had come into operation as a continuing cause of the rheumatic state. We might ask here, how does this mechanism account for the predilection of attack on the mitral valve? It is a constant difficulty in hypotheses which do not attribute the disease entirely to an infective agent to circumvent this point; just as in syphilis the aorta is the site of election, so in rheumatism is the mitral valve. Bradley also mentioned that in his work on hepatitis it had been noticed that patients with rheumatoid arthritis contracting this disease were relieved of their symptoms.

In public health we are more concerned with the preventive aspects of the disease. Bradley considers the preventive approach under four headings—detection of genetically predisposed persons, chemotherapy to prevent relapses, protection against *Str. pyogenes* infection of those genetically predisposed, limitation in size of rheumatic families. Could measures based on these principles be introduced in a community? It would be possible to detect from family experience some individuals who were predisposed and to institute measures for their protection; but would it be possible to limit their propagation?

\* Abridged in the *British Medical Journal* (June 24th, 1950), 1, 1487.

We know the uphill fight that is our daily life in inculcating simple measures into the community to improve the general health; how much more difficult to advise certain individuals against marrying the partner of their choice because the two of them are rheumatically predisposed and are probable progenitors of another rheumatic generation!

Bradley's suggestions for a regimen for children of rheumatic parents—that they should be housed in separate bedrooms, brought under surveillance, adequately nourished and encouraged to protect themselves against upper respiratory infections—are wise, but surely devolve on the more difficult problem of proper housing in the first place. Much of preventive work to-day is devoted to healing the scars of bad and inadequate housing and its attendant ills. Ideally every child should have a separate bedroom. The community is asked to increase its family size and to raise its standard of living; meanwhile houses of size and standard contrary to these requirements are being built. It is hoped that it will soon be realised that prevention is better and less costly than cure in the long run. In order to assist in control measures, notification of acute rheumatism and the setting up of rheumatic supervisory centres would be necessary and should be arranged in each local health authority. Through the notifications of scarlet fever some indication is given of the distribution of *Str. pyogenes* in the community, but it has long been realised that this is a very incomplete picture owing to the protein manifestations of the organisms. Notifications of all streptococcal infections might be a valuable measure—segregation of cases of tonsillitis due to this organism is equally important with or without the rash. Through the supervisory centre co-ordination of the attack upon the rheumatic state could be managed; it would form the headquarters of the offensive envisaged in Bradley's preventive principles.

### The Coxsackie Viruses

Of the findings of new viruses there is no end. There are viruses from tropical areas, complete with vectors, but unattached to any clinical syndrome. There are now not many clinical syndromes without any attached virus. This was true of the disease, or diseases, known variously under the titles Bornholm disease, epidemic myalgia or myositis, epidemic pleurisy, Devil's gripe, etc., but now so high an authority as Findlay claims for the Coxsackie viruses 1 and 2 a causal connection with this group (Findlay and Howard, 1950).<sup>\*</sup> Diseases of this group are widespread, and not uncommon in Britain, as Pickles notably in 1933 reported them from his rural district; indeed, the present writer has had the unpleasant experience of such an attack.

The Coxsackie virus was first isolated in 1947 by Dalldorf and Sicks from the stools of a supposed non-paralytic case of poliomyelitis in the village of Coxsackie in New York State; it has been reported elsewhere in the United States in 1948 by Melnick and others in similar circumstances.

The latest North American observations come from Canada,† the virus having been found by the Toronto team associated with or separate from the poliomyelitis virus in actual cases or contacts of that disease in an area to the north of Ontario. It was also isolated by them from a case of Guillain-Barré-Landry syndrome. The type of virus is unstated by these authors. Six persons, four children and two adults, showed the simultaneous presence of the two viruses—poliomyelitis and Coxsackie. There was some evidence of the production of virus neutralizing antibody. There are now five known types of this virus, the complement fixation test being mainly relied on for differentiation.

The evidence of the causal association of at least two of the Coxsackie strains with Bornholm Disease is strong but perhaps not yet conclusive. Evidence of the virus was found in cases of, and in sera from reported convalescents from, Bornholm

disease in this country, e.g., London, Richmond and Wensleydale, in which the No. 2 virus was incriminated. One of the laboratory investigators, presumably not in contact clinically, suffered a fairly characteristic attack of Bornholm disease. Further investigations will be eagerly awaited. At the moment the discovery of Coxsackie virus seems to complicate the already difficult task of identifying the poliomyelitis virus, of which there are three main antigenic types with a number of sub-varieties.

### The Nuffield Foundation

The fifth report of the Nuffield Foundation\*, whose trust deed directs that one of its objects shall be to further research and education for "the advancement of health and of social wellbeing," refers to the completion of the first quinquennial programme and goes on to record the first year of the new programme. Its resources are the income from the foundation gift of £10,000,000 from Lord Nuffield and the Oliver Bird gift reported last year of £450,000 for the promotion of research into prevention and cure of rheumatism. (The total allocated from this year's income for the second five-year programme is over £500,000.) The Bird gift has acquired particular importance since the American discovery of the relation between adrenal function and rheumatoid arthritis; and the present report describes the support being given by the trustees to work on cortisone and A.C.T.H. at various biochemistry centres and at St. Mary's Hospital Medical School under Prof. G. W. Pickering, where it is hoped that the collaboration of Sir Alexander Fleming and Prof. R. Cruickshank, of the Wright-Fleming Institute may be particularly valuable in throwing new light on immunity and allergy. In this field close liaison is being maintained with the M.R.C. and the pharmaceutical industry.

Projects to which the Foundation's support is being continued from the past programme include the radiological research into normal health at the Nuffield Institute of Medical Research, Oxford; health in the linen industry, under Prof. A. C. Stevenson at Queen's University, Belfast; the second follow-up of children born in one week of March, 1946, by the Joint Committee of the R.C.O.G., Population Investigation Committee and Institute of Child Health, London, with which health departments are so closely associated; the study of child development by the London Institute under Prof. Moncrieff; and a nutritional survey of old people living on their own by Prof. W. Hobson's department at Sheffield.

Fundamental research, mainly in biological and sociological studies, on the assumption that "all knowledge is potentially useful," attracts £80,000 of the new budget for work in the United Kingdom and £25,000 for the Commonwealth overseas. Fellowships, scholarships and similar awards already announced in our pages, are allotted £225,000 from this year's income, leaving another £173,000 to be met during the remainder of the five-year period. Under its object "the care and comfort of the aged poor," the Foundation is to pay over to the National Corporation for the Care of Old People the balance of the half a million pounds promised.

It will be seen that the Foundation's funds, wisely administered in accordance with its trust deed, are still acting like a refreshing stream for research and education in fields where the State is not concerned to spend money, since there is no political mandate. Such independent and disinterested aid has gained immeasurably in value and influence since the passing of recent health and welfare legislation. Long may it continue to carry out its founder's wishes.

### The Society's Office

On and after September 25th the Society's office will be on the third floor of the newly opened extension of Tavistock House South. The approach is by the same entrance (Entrance C) as hitherto, thence first left and then right from the lift.

\* *Brit. Med. J.* (May 27th, 1950.) 1, 1233.

† ARMSTRONG, M. PATRICIA, RHODES, A. J., et al. Studies on Poliomyelitis in Ontario. (1950.) *Can. J. Pub. Hlth.*, 41, 51, 183.

\* 12 and 13, Mecklenburgh Square, London, W.C.1.

## SOME ASPECTS OF EPIDEMIOLOGY \*

By JOHN YULE, M.D., D.P.H.,

Medical Officer of Health, County Borough of Stockport

"Epidemiology is something more than the total of its established facts. It includes their orderly arrangement into chains of inference which extend more or less beyond the bonds of direct observation."

W. H. Frost.

## I. Historical Review

The history of medicine is always a fascinating study and there is no more interesting branch than the history of epidemiology.

It is a far cry from the realms of demons to our modern conception of epidemiology and the evolution of human thought and experience is worthy of careful examination.<sup>1</sup> How did the leaders of science really visualise a given problem in a given century? What was their solution and what were their reasons for dictating that solution?

Demons, miasms and germs are obviously the three concepts which have dominated human thought, but there are many subsidiary questions that intrigue the imagination.

The analysis of the beliefs and practices of primitive peoples, for example, arouses distinct respect for the logic of the procedures designed to ward off or propitiate the demons—once the basic premise of personal malign forces has been granted. The Old Testament theory of pestilence as a punishment for sin emerges as a concept on a far higher spiritual and intellectual plane than that of demonic possession which dominates the New Testament. A middle course between demonology and objective science moves in a field of abstract intellectual conception rather than a world of physical fact. The qualities which are common to magic and science and those which distinguish these two points of view have a direct bearing on our understanding of superstition in the world to-day.

The fifth century B.C. in medicine, as in every other field of human thought, for the first time revealed the inspiring vision of a world no longer the playground of chaotic personalised forces but an orderly universe of law. That the actual chain of causation postulated by Hippocrates was incomplete or erroneous is of little moment. It was a chain which lay in the field of objective and observable fact, each link of which could be checked, each theory corrected by submission to the tests of controlled experience.

Greek hygiene and Roman sanitation were marked by significant contributions to the cause of public health.

With the fall of classic civilisation, there came a tragic recession under the shadow of the Dark Ages—when from A.D. 400 to 1,000 no one in the field in Western Europe contributed a single new thought to the stream of human knowledge, and the pendulum swung back towards primitive demonology.

With the spread of leprosy in the sixth century, the practice of isolation was once more emphasised. The pandemic of bubonic plague which began in 1348 led to a widespread acceptance of the doctrine of contagion embodied in hundreds of Plague Tracts which represent the first great effort at popular health instruction. The epidemic of syphilis about 1500 accentuated this lesson and in the 16th century, Fracastorius—the second great figure in the field after Hippocrates elaborated a clear and convincing doctrine of contagion even though he conceived of the contagious element as a gaseous emanation rather than a living organism.

Thomas Sydenham was by no means as good an epidemiologist as a clinician. He tended to ignore not merely the germ but the whole fact of contagion and led medicine back to an emphasis on mystical conceptions of unknown and unknowable atmospheric influences which was far more extreme than that of Hippocrates himself. The Greeks used the concept of an "epidemic constitution" of the atmosphere to explain individual phenomena which could not be understood on known

objective grounds. Sydenham made it the whole basis of his epidemiological thinking.

It is interesting to note that for centuries laymen were generally contagionists and physicians were miasmatists. Nor was this due to traditionalism or prejudice on the part of the medical profession. The layman observed certain phenomena and jumped at the conclusion of contagion. The physician, knowing more, was quite correct in denying that any then available theory of contagion could explain the facts. Richard Mead in the 18th century harmonised the contagionistic and miasmatic views with a skill which makes him the third great epidemiologist in the lineage from Hippocrates.

The history of epidemiology is an excellent example of the relativity of scientific theory. Even physics to-day claims no absolute and unconditioned laws but only deductions as to the validity of certain relations when other factors are constant. All that we can demand from a scientific "law" is that it shall "work" under specified conditions. The "great sanitary awakening" of the middle 19th century was based on the assumption that disease was generated by decomposing filth. Crude as this conception was, it had in it enough truth to work; for dirt, if not the mother, is the nurse of disease. When Chadwick and his followers cleaned up the masses of decomposing matter in which our forefathers lived (and died), the prevalence of typhus, typhoid and cholera was strikingly reduced.

From 1850 to 1890, the empirically-justified theory of disease was gradually transformed into a more complete formula. Snow and Budd proved the importance of water supply and direct contact by some of the most competent investigations in the history of epidemiology. At last came the unrivalled brilliance of Pasteur and the firm establishment of the germ theory of disease.

The structure of modern epidemiology was, however, not yet complete. Throughout the latter half of the 19th century, Pettenkofer at Munich carried on a gallant last-ditch battle for the local miasmatic factors in the production of pestilence.

The germ theory, as developed by Pasteur, still left unsolved two major enigmas, the occurrence of cases among persons who had no contact with the sick and the failure of many persons in intimate contact with the sick to develop disease. The first of these enigmas was solved by the demonstration of the importance of the well-carrier and the insect host; the second by an understanding of the low viability of the disease germ and analysis of the modes of infection. The germ theory of disease at last stood four-square—one of the outstanding achievements of the mind of man.

## II. Modern Concept

## (a) Definition

It is important, therefore, that we should give consideration to the ever-changing concept of epidemiology. The question, what is epidemiology has been asked many times and answered in diverse ways. It is, of course, the study of the whole people and any restriction of its field to the study of infectious diseases alone is now quite outmoded. It is the study of man as an individual and a member of the herd.

A full and true appreciation of the complexity of the problem must have its basis in physiology. Man is a finely adjusted physiological instrument and sensitive to the infinite variations of the environment in which he lives and has his being.

## (b) Man as an Individual

The varying manifestations of disease in any one individual at any one time is dependent on an infinite variety of conditions; the gênes from which he springs; his nutritional state; whether or not he suffers from vitamin deficiency; the state of his endocrine equilibrium; temperature and seasonal variations; the atmosphere he breathes; the food he eats and what he drinks; in other words the whole environment and his reactions to that environment. These are but indications of the wide variations possible in one individual. Added to these, in recent years, Halliday has shown the importance of psycho-somatic disease and psycho-social disease.

\* Paper presented to the annual meeting of the County Borough Officers of Health Group, Society of M.O.H., Scarborough, June 4th, 1950.

### (c) *Man as a Member of the Herd*

In considering man as a member of the herd the greatest contribution to scientific practice has been made by Topley, Wilson and Greenwood. They have indicated why, although each member of the English herd is susceptible and would fall an easy victim to plague if he strayed from the herd, in this country the association of man, the rat and the flea is not now of a kind to allow spread along natural routes.<sup>3</sup> The herd is probably immune to cholera as the result of an adequate system of water purification. It is not, nor does it seem likely to become immune to any of those diseases that are spread by droplet infection.

Many of the most striking successes of preventive medicine have been attained by altering herd structure without inducing an increased resistance in the individual members. By attacking insect vectors of infection, such as the mosquito, by preventing the frequent passage of bacteria from one person's intestines to another person's mouth by way of water and food, and by a general improvement in environmental conditions we have succeeded in eliminating or reducing to negligible proportions, diseases that formerly took a heavy toll of lives and still take that toll in areas where such measures are not applied.

## III. The Nature of the Problem

### (a) *General*

A study of the contributions made both in the laboratory and in the field in the solution of the great epidemiological problems of plague, yellow fever, cholera and smallpox, afford ample evidence of the infinite variety of factors that have to be considered in the study of any one major epidemiological problem.

The entities with which the epidemiologist deals are epidemiological and not clinical in nature.<sup>4</sup> There is no more serious fault in our practical defences against communicable disease than our habit of dealing with scarlet fever, septic sore throat, puerperal fever, erysipelas and otitis media as different clinical entities, not as manifestations of one epidemiological entity. Our problem is complicated by the splitting up of so many so-called species of pathogens into serological types. Even if the chemical processes involved in pathological reactions to an invading germ were identified, it would still be important to realise the complexities involved in the answers given by the human body to the insults offered by foreign invaders. We must never be blinded by the over-simplified conception that we may discover the cause of any disease. The tuberculosis bacillus is not *the cause* of tuberculosis. It is *a cause* of tuberculosis. You cannot have tuberculosis without the myco-bacterium; but half the people whose tissues have been invaded by the myco-bacterium as shown by tuberculin tests suffer from no disease in a clinical form, although they no doubt show minor pathological reactions to the invader.

### (b) *Variations in the Organism*

Variations in the organism are exemplified in smallpox. We know that in the decade 1920-30 there were in this country some 10,000 cases of variola minor. The clinical syndrome was in most respects similar to that of variola major but the constitutional upset and death rate were negligible. Experience in those ten years showed that variola minor always bred true. The bacteriological postulate that the organism would increase in virulence by passage was not confirmed by experience. It may be that the time factor was too short. On the other hand, variola major still demands a heavy death rate when it makes its few sporadic incursions into this country as shown by the recent experience in Glasgow. We know that efficient vaccination protects against both. Moreover, experience would appear to indicate that there is a relationship between variola, varicella, and herpes zoster. Long experience has led to the confirmation of many facts but the enigma still remains unsolved.

### (c) *Vital Resistance*

Inherent vital resistance plays an important role in every departure from normality sufficiently marked to be labelled as disease<sup>5</sup>. We rarely know what this means; but we do know

that it means different things in different diseases, and that it is a factor of major importance. Read the accounts of the attempts to climb Mount Everest and note the different reactions of different individuals to extremes of cold and fatigue. Study the records of accident-prone car drivers and realise the important role of neuromuscular balance in so apparently simple phenomenon as a mechanical accident. In the clash between a human body and an invading germ the differences between individuals in the field of biochemistry are equally significant.

### (d) *Nutrition*

Nutrition may be in many instances, a vital factor in the defensive mechanisms of the body. Aycock held the view that vitamin deficiency as a factor in susceptibility to infection is not a general epidemiological principle. The indications are that only deficiencies of certain vitamins affect susceptibility to certain types of infections and that these occur only in limited areas where these vitamin deficiencies reach a sufficiently severe degree to produce tissue changes which are favourable sites for secondary infection. There is doubt however, whether the prevalence of typhus fever is due in times of famine only to poverty and increased infestation of lice. Moreover, in tuberculosis the relationship of under nourishment to increased morbidity and mortality cannot be questioned.

## IV. Climate, Season and Temperature

### (a) *General*

The influence of climate and seasons on the incidence of disease has been apparent since the earliest times. There is a tendency, however, for this aspect of the subject to be overlooked. In those diseases which are disseminated by a specific vector, the influence of season is obvious and clearly recognised. What is commonly ignored, however, is the peak of intestinal diseases in hot climates and seasons and of respiratory infections in cold climates and seasons. It seems clear that in these instances the phenomena cannot be explained by influence on the parasite but must be sought in the physiological status of the human host. The fact that Dick and Schick tests in warm climates show the same infection rate as in cold climates, with an insignificant rate of clinical disease, is proof-positive on this point.

North, many years ago, suggested that one very simple factor of seasonal physiological variation was the relative distribution of body blood to the intestinal and naso-pharyngeal mucosa at different seasons.

### (b) *Plague*

A personal experience which I had, proving the importance of temperature and seasonal variations in the spread of bubonic plague may be of interest. The ship, s.s. *Tirreno*, which left the River Plate during the summer in the Southern hemisphere and arrived at the Port of Hull in the month of April, with a cargo of loose grain, was found to have an epizootic of bubonic plague. With the holds battened down the summer temperature under which the grain had been loaded had been maintained in the holds, providing the necessary conditions for the survival and multiplication of *xenopsylla cheopis*. The ship with full cargo was fumigated with cyanide and some 270 rats, many in a mummified state, were found when the loose grain was loaded into barges through improvised sieves of chicken wire. The ship was again fumigated with cyanide when the cargo had been discharged. Only three rats were found, none of which was suffering from plague.

The important point is that although the rat-flea relationship necessary for spread was provided, the link with man was broken as soon as the holds were opened up and the habitat exposed to the rigours of our spring.

On the other hand, another ship from the River Plate arrived in Italy about the same time with an epizootic of plague, and there were as a result several cases of human plague.

As an aside it may be stated that two further practical difficulties arose in dealing with this plague-infected ship. The receivers of the grain, which was valued at several thousand pounds, were concerned whether or not the faeces from the plague-infected rats would render the grain unfit for human

consumption, secondly, whether the moistened grain would absorb sufficient cyanide to make it unsuitable for human consumption. The answer to the first of these questions is given in that admirable survey, "the Report of the Indian Plague Commission," the second, by submitting samples of the grain to chemical analysis. Fortunately, we were able to reassure the receivers of the grain that it could be used for human consumption. We know, of course, that plague will not spread unless the cheopis-index rises well above one, and by flea-surveys in our various ports it has been found that this is only likely to occur in the warmest summer months.

It is interesting to note that though there have been a number of importations of bubonic plague into this country since the beginning of the present century only on one occasion has the infection survived over our Winter without re-importation of new infection. The case in point was in Glasgow about 1902 when the rats found the ideal temperature around the hot water system in the basement of a Glasgow tea-shop.

(c) *Poliomyelitis*

A consideration of the influence of season and temperature as a factor in the spread of poliomyelitis provides a subject both of topical and fascinating interest. A great amount of work has been done on this subject, particularly in America. Certain facts are known. Our experience in 1947 and 1949 in this country confirms our previous knowledge that, as a rule, poliomyelitis in this country only assumes epidemic proportions in late summer and autumn. The virus has been found both in the upper respiratory passages and in the stools. There has been a tendency to depart from the formerly generally accepted view that the only portal of entry was the upper respiratory tract, to the opinion that the bowel may provide not only a second portal of entry, but probably the commoner one. Bowel infection becomes the more feasible theory because of the summer and autumn incidence of the disease. Moreover, lower motor neuron involvement is much commoner than involvement of the bulbar nuclei. There is cumulative and generally accepted evidence that exposure and exercise are important contributory factors in poliomyelitis.

The challenge still remains as to the reasons for the lower motor neuron involvement in some cases, the bulbar nuclei in others and a combination of both in a still further group. A vast accumulation of established facts and experimental evidence is available, but no-one has yet had the wit to understand them and complete the chain of inference which lies beyond the bounds of direct observation.

(d) *Influenza*

Influenza is a disease which to-day challenges our attention under several heads.\* It is an endemic and epidemic killer always amongst us, and has within the recent past given rise for no immediately apparent reason to a world-wide pandemic more destructive to human life than a modern war. Our knowledge of its viral origin has increased greatly in recent years, but in a sense our knowledge of its epidemic incidence has diminished, for if the strains and stresses of the Four Years' War be held accountable for the catastrophe of 1918-19, there has been as much misery, want and disorganisation in Europe as a result of the last war and of its sequelae, but no epidemic of influenza or of any other disease has arisen in any remotely comparable manner. In fact from the mid-30s onwards the death rate from influenza in this country has shown a generally declining trend, which, if it continues will again reduce this disorder to the unimportant place as an enemy of human life which it held during the third quarter of the last century.

(e) *Measles*

Measles is another example of a disease showing its highest incidence in the winter and spring and more virulent and extensive in alternate years. There is no doubt that the physiological state of the upper respiratory mucosa is an important factor in the successful implantation of the virus infection. The two years' cycle indicates that balance between non-immunes and the carrier rate dictates epidemic prevalence. The work of Halliday showed that in Glasgow the close congregation of

the herd in the tenement system led to increased rapidity of spread. The climatic conditions of a Glasgow winter combined with atmospheric pollution are important considerations in leading to the increase of broncho-pneumonia and consequent increase in the morbidity and mortality rate. The introduction of the anti-biotics and the sulphonamides has of course had an important influence in reducing these rates.

V. Conclusion

These are but a few loose and sporadic sallies of the mind on a vast subject.\* It may well be that the variable factors awaiting discovery in respect of many infectious and non-infectious maladies are more numerous and more complicated than in those examples which have already yielded or partially yielded their secrets. We must always bear in mind, moreover, the lesson repeated over and over again by history and never easy to learn, that techniques supremely effective for dealing with past problems may be a hindrance in an open approach to new difficulties.

The problem is as complex and difficult as Einstein's theory of relativity of the universe. There are few absolutes even in ultimate solutions and many more relative findings. However, in view of what has been accomplished in the past we may yet travel hopefully with good prospects of safe arrival.

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PREVENTIVE PSYCHIATRY \*

By ALFRED TORRIE, M.A., M.B., D.P.M.,  
Medical Director, National Association for Mental Health

Let me begin by a question, are psychiatric conditions preventable? If we believe that all psychiatric conditions, like feeble-mindedness, are bred in the bone, then we feel that preventive measures are not of much use. If, on the other hand, we feel that strain and stress, if great enough, can cause a psychiatric breakdown even in the strongest personality, then we can devise measures for adjusting these strains and stresses to the capacity of the individual to tolerate them.

This last statement is important, as a scheme of preventive psychiatry which removes all strains and stresses would defeat its purpose, in that it would prevent the development of the personality of the individual. Frustration is inevitable and it is a question of finding the optimal amount of frustration which the individual can tolerate and as a result of which he would develop strength of personality.

The foregoing implies that environmental factors or nurture have a part to play in the development of psychiatric conditions. The old argument of nature *versus* nurture is not necessarily relevant, as both have an influence. There may be an inheritance of constitutional pre-disposition to reacting to environmental stress in an unsatisfactory way. This varies with the individual, but recent experience of well thought out measures from the mental hygiene point of view, has demonstrated that the inherited factor can often remain latent, unless brought to light by environmental strains and stresses, greater than the individual can tolerate, so that the over emphasis on the genetics school in the past has delayed our thinking of preventive measures in psychiatric conditions because we have felt that these were mainly confined to idiots and lunatics and that nothing could be done about it except to remove them to places of safety.

It is over 100 years ago since Chadwick and others following the panic brought about by large-scale epidemics of infectious diseases began to devise preventive measures and work out methods of tackling sources of infection. He had much opposi-

\* Address to the County Medical Officers of Health Group, Society of M.O.H., London, June 9th, 1950.

tion from the established order in medicine, whose theories of causation were rigidly held. Much of the good health of our nation, in the physical sense, is due to the pioneer work of these earlier physical hygienists, and this has been carried on by you to the present day.

I think that the preventive side of psychiatry can well develop on the lines of the campaign which brought about an improvement in the figures of deaths from tuberculosis of all kinds.

You know this field better than I do, but historically speaking, tuberculosis was looked upon with horror and dread, as an evil visitation or a punishment by God for wrong doing by the patient. He or she went into a "decline." The condition was spoken about with bated breath, and many superstitious ideas about blocking up the windows, etc., as we saw in "The Barretts of Wimpole Street" play, were prevalent. Gradually more accurate diagnosis and localisation cleared up much of the mystery, and then the detection of Koch's bacillus meant a tremendous advance. From there the search went on for sources of infection and bit by bit hygienic measures were introduced, housing, nutrition, segregation, tubercular-free herds of cows, etc., and then last of all the goal and aim of all public health was introduced, namely the maintenance of positive health, and mass miniature radiography brought about the detection of incipient cases when the individual appeared in good health.

#### Prevention of Psychiatric Conditions

Such a campaign could proceed in the same way as the one just sketched. The first thing, of course, is the proper education of the public so that the idea that mental illness is akin to possession of the devil and so on, could be eradicated. If it could be shown that much mental ill health can be remedied, if detected early enough, and that measures can be taken to prevent its onset, then a great deal of the superstitious fear of these conditions would vanish. First of all, accurate diagnosis is necessary and accurate diagnosis depends upon a proper understanding of causation. We cannot say we have found all the causes of mental ill health, but we do know that many predisposing factors have been investigated and found to have relevance. The diagnosis of mental ill health is more clearly understood if we can satisfy ourselves as to what mental health is. Several definitions have been given and these definitions have to be thought of in the light of the World Health Organisation's charter which defines health as "the state of complete physical, mental and social well being, and not merely the absence of disease or infirmity." This comprehensive definition recalls the definition of psychiatry given by a Committee of the Royal College of Physicians, namely the study of human behaviour in its social setting, and thus psychiatry is brought into close relationship with social medicine.

Mental health has been defined as the state of mind of one who is satisfactorily adapted to his environment, and to the needs of his own personality. Another description recently given by Hadfield is "the full and harmonious functioning of the personality." It will be seen by these statements that much mental ill health is a matter of maladjustment of the individual to his social environment. It is a problem of relationship and is a social disease. Mental illnesses are modes of reaction and are not entities in themselves. The more recent classifications of these disorders places them under the heading of "reaction types." We must also note that psychiatric conditions are not divorced from physical well-being and every psychiatric condition, in my view, is also a psycho-somatic condition. There is some physical tendency to break down which is brought to light by strains and stresses of various kinds. The same is true, of course, of tuberculosis. There is the physical diathesis which does not become operative until the bacillary infection and other contributory events occur. Some mental illnesses are mainly physical in origin like the psychiatric concomitants of puerperal sepsis, and other infectious illnesses, poisons, alcohol, lead, syphilis, etc. The type of reaction is closely linked with the previous personality of the patient. Then there are conditions which are both physical and psychological, but are more psychological than physical, such as psycho-somatic illnesses proper, which were often attributed only to allergy in the past. These include asthma, migraine, colitis, urticaria, the

various neurodermatoses and disordered action of the heart (the old D.A.H.), which has died the same death as railway spine and shell shock, once the psychogenic nature of the conditions was fully accepted.

There are illnesses that are mostly almost wholly psychological—such as anxiety states, depressive reactions, schizophrenic reactions, hysterical reactions, although the latter have a mask of physical symptomatology.

Many psychiatric disorders can be prevented from developing by early detection. Enough is not taught about early signs and symptoms. These, of course, appear in the man's everyday setting, in his home, and at his work, and during his recreational pursuits. His family, his workmates and supervisors at work, and his fellows who join his leisure pursuits, are aware of the changes of behaviour that increase in intensity and eventually lead to his seeking, or being sent to seek, medical care. Many a case of depressive illness can be prevented from a disastrous conclusion, like suicidal episodes, by recourse to proper diagnosis and specific treatment. Endogenous depression and melancholic conditions respond very readily and rapidly to electro-convulsive therapy. The diagnosis, of course, depends on previous family and personal history. The same signs and symptoms can also precede conditions other than melancholia. A knowledge of these indications of early disease can be as useful as the information given by the Cancer Campaign authorities to middle-aged women.

#### The Prevention of Relapse

When a patient has been a considerable time in a mental hospital and has recovered sufficiently to be sent home as the care of his relations, he is not completely able to settle down as an ordinary citizen again. He requires skilled help and his family require help in this process of adaptation. If this help is not forthcoming, the strains and stresses of the world outside the seclusion of a mental hospital may become too much for him again and he relapses and has to be re-admitted. The percentage of re-admissions to mental hospitals is very high and once again a bed is occupied and a long period of fresh treatment is started and much expense and medical and nursing time involved.

With tuberculosis we are very careful that when the patient is discharged from the sanatorium, he is told to attend regularly at a clinic for a frequent check up. His chest is x-rayed and his sedimentation rate worked out, his home is visited and such environmental conditions as are remediable are dealt with. This goes on for a period of years, I believe. The discharged psychiatric patient is equally in need of the same kind of follow up. This was allowed for under Section 28 of the National Health Service Act of 1946. It is an excellent idea in theory, but in practice there are not enough trained workers to do the job as we would like to see it done. The community care of the mentally convalescent is an urgent necessity, as the demand for mental hospital beds almost equals that for other types of patients, and they are an even greater economic loss. The recovery rate from mental hospitals of those who have responded to treatment compares very favourably with those discharged from hospitals after physical illnesses. It seems to me that those local authority employees who already are accepted in the homes of the people, could in part be given some orientation into the nature of this work. I refer to the health visitor. Not every health visitor is by temperament or personality suited for, or has a liking for, work with psychiatric patients. Some are suitable and these should have in their refresher courses enough training to help them to detect signs of strain or stress in the discharged mental hospital patient so that they may take action for measures of prevention of relapse, either by referring to a psychiatric social worker or to an out-patient clinic, or by early re-admission to ensure a shorter second stay in the hospital. I know that this question of the community care of the former mental hospital patient is a very controversial one. There is a school of thought which avers that the need of these patients is material welfare only, but I am sure the same exponent of this idea would not apply it to the convalescent from tuberculosis.

The main point about material welfare is that the patient pre-disposed to psychiatric illness is more emotionally affected

by difficulties in this field than the patient not so pre-disposed. There should be co-operation and co-ordination between the welfare officer and the mental health worker, so that the welfare officer, with some training in the early signs and symptoms of emotional breakdown, would be able to call in the mental health worker to deal with the mental health aspect of the case.

The recommendation of the World Health Organisation for the orientation of health visitors into general mental health principles is a sound one. The addition of mental health items of the Royal Sanitary Institute's syllabus for health visitors is welcomed.

#### Education of the Public

Section 28 of the National Health Service Act empowers an authority to take measures for the education of the public, with a view to the prevention of mental and physical illnesses. Since most of the pre-disposing causes of mental ill health begin in childhood, often as a result of faulty family relationships, the first step should be better training in parent-craft, from the psychological angle. The health visitor can give much information of a psychological kind, along with general instructions for the management of the physical health of the child. Parent-craft should begin before the child is born and the practice of dealing with the emotional condition of the pregnant mother in some clinics in this country deserves development.

In addition to the parent, others have the responsibility of handling the individual throughout his life and of creating attitudes and patterns of behaviour which give emotional security and so maintain mental well-being. These include teachers, industrial supervisors, welfare officers, trade union officials, youth leaders, magistrates, probation officers. The mental health education of these professional workers would pay larger dividends than dissemination of information to an unselected group. These people are in the position of leadership and their method of handling those for whom they are responsible can make or mar the quality of their emotional security. Simply written pamphlets can give general principles of the mental health of children and adults and of the measures for maintaining good morale in the class room, factory and other environments. Films have an even better effect, provided that they have been made in accordance with agreed psychological principles.

The teaching of mental health is a difficult matter, because in discussing emotional development, we cannot divorce our information from the capacity of the individual to receive it. This capacity is affected by his own up-bringing and experiences and his own rigidity of mind or capacity to develop new attitudes. In fact, the practice of public health education can only be effectively carried out if what is said is adapted to the needs of each individual listener. Only in a group discussion can each listener express what his own particular needs are.

#### The Place of the Child Guidance Clinic in Preventive Psychiatry

The younger the child the more easily is his behaviour modified. Later on his modes of reaction to environmental changes become set, and there is less chance of developing a good therapeutic result. The most successful child guidance clinic I know is for the pre school child, and the best results are found in children around about four years of age. The infant welfare clinic can help the mother with psychological difficulties. The Education Act of 1944, with its provisions for the maladjusted child, is apt to concentrate on school age. There are various interpretations of the Act, with regard to the teacher and the doctor. Treatment should always be preceded by diagnosis and the early diagnosis of psychological ill health in a child is not the vested interest of any one person handling the child, but should be a team matter. The educationist, school medical officer, child psychiatrist, psychiatric social worker and the psychologist, all have a contribution to make to the diagnosis. When this is made, then the treatment can be undertaken by the appropriate member of the team.

The child psychiatrist requires to be doubly qualified. He must have had a training in adult psychiatry so that he may understand the end results of conditions beginning in childhood. He must also have had experience in working in a child guidance

team. The child guidance team has a very high priority on the list of measures of preventive psychiatry.

#### Mental Hygiene for Other Groups

Teen-agers have many emotional problems which require help. Many of them are normal in a stormy transitional period of life. No special provision is made for the post-school child, who is still only half an adult. In fact one Regional Hospital Board during planning, felt that since most adolescents had emotional problems, no special provision was necessary. Yet I feel that since adolescence is the last occasion on which preventive measures will be really effective (because at that time the individual is still capable of forming new patterns of behaviour) it is most important that adolescent guidance clinics should be available. Such a clinic should be in the nature of a counselling service and removed from the atmosphere of mental ill health. Only then can the teen-ager with difficulties be persuaded to have help. A child guidance service and adolescent counselling service offers best measures for the reduction of the incidence of juvenile delinquency.

The incidence of strikes, high sickness absenteeism, due to psychological causes, and poor morale, are often related to mental ill health. Mental health measures in the hands of welfare officers and personnel officers can lead to better relationship in factories, and a public mental health officer might well make advice and guidance to industrial centres in his area a useful part of the duties of his department.

One county council has set up a chain of advisory bureaux where individuals suffering from emotional conflicts can have advice and direction. The difficulty is that unless they are staffed by workers sufficiently skilled to classify the cases, they may turn into alternative out-patient clinics.

Geriatric medicine has proved that the psychological and emotional adaptation of the aged is often a difficult matter and that many a case of senile dementia can be prevented by the detection of early signs and symptoms and by suitable measures to promote adaptation.

#### Summary and Recommendations

1. It is suggested that mental hygiene can make as much progress as physical hygiene has done, if medical officers of public health also become medical officers of Public mental health.
2. Section 28 of the National Health Service Act gives full powers for a programme of preventive psychiatry.
3. Mental health education of leadership groups, mental hygiene teaching in ante-natal and infant welfare clinics, the development of a child guidance service for all age groups under 20, the development of an industrial mental hygiene programme, and the setting up of a counselling or advisory bureau, are suggested.

#### THE HAMPSHIRE PREVENTIVE MENTAL HEALTH COMMUNITY CARE SCHEME\*

By H. LESLIE CRONK, M.A., M.D., D.P.H.,

*County Medical Officer of Health, Hampshire*

Circular 146/48 of August 25th stated *inter alia* that "the Medical Officer of the Service Hospital from which the patient is discharged will report the case to the Regional Hospital Board of the area in which the patient will be residing. If the report indicates that specialist treatment is needed the Regional Hospital Board will arrange this, but if specialist treatment is not required, the Regional Hospital Board will send particulars of the case to the Local Health Authority which will then provide the Community Care." This circular suggested two means by which the local health authority could give this care, *viz.*, making use of the National Association for Mental Health or employing its own psychiatric social workers. It appeared that there would be some difficulty if two authorities were competing in the very limited market for psychiatric social

\* Paper read to the County Medical Officers of Health Group, Society of M.O.H., London, June 9th, 1950.

workers and some duplication of effort and waste of scarce personnel if staff were obtained. Moreover, should the patient attend a specialist and were then handed over to the local health authority, a change of psychiatric social worker would be undesirable. It was therefore considered that an effort should be made to obtain agreement that psychiatric social workers employed by the Board might be made available for such services as the county council might require.

Arising out of this, it appeared that this service might be expanded to include prevention as well as after care.<sup>†</sup> After some discussion therefore it was agreed that at a number of centres so situated that all parts of the county should be served, some rooms would be set aside where the psychiatric social worker could give advice and help to all referred to her through whatever channels. A large number of organisations were circulated, doctors practising in the county, teachers at schools and clergy, together with the larger employers of industry. In order that there might be very close liaison between the psychiatrist and these "Advisory Bureaux," as they were called, an out-patient session was arranged by the psychiatrist either in the same building or in the vicinity (at half of them actually simultaneously with the Bureau).

This scheme came into force on February 1st, 1949, and bureaux were opened at six centres in the county area, to which a seventh was added shortly; use was also made of facilities available at Portsmouth and Southampton. It was anticipated that the usefulness of such a scheme would not be shown straight away but actually there was quite a fair amount of work in some places owing to the continuation of supervision formerly undertaken by the National Association for Mental Health. Interest, however, never developed and during the last three months of the first year of working only 14 new cases were seen at all nine bureaux, i.e., in 108 sessions. Of these 14, seven were referred directly by doctors with a view to treatment by the psychiatrist.

During the whole 12 months the scheme was running, 156 cases were seen, some of them of course several times, of whom 57 were referred to the psychiatrist, 13 to their own doctor, 22 admitted to hospitals and the others dealt with in other ways. During February, 1950, the whole scheme was reconsidered and a report was made to my Committee as follows:—

"In my report to this Committee on October 13th, 1948, I stated that the Psychiatric Social Worker should be the person responsible for ascertaining most of the cases in need of help, for giving the help needed, and persuading those that needed medical advice to see the doctor. In practice this has failed while the Area Welfare Officer has been successful.

"The Medical Superintendents are unanimous in stating that as patients are visited by Psychiatric Social Workers until no further supervision is needed, this after care work is a matter for the Regional Hospital Board and not the Local Health Authority. Dr. Garmany, Regional Psychiatrist, did not dissent from this view in ex-service cases previously dealt with by the National Association for Mental Health, but considered it essential that all such cases be referred to the psychiatrist in the first instance, either directly or *via* the Local Health Authority.

"Since, therefore, the employment of psychiatric social workers on the staff of the Hospital Management Committees by the Local Health Authority appeared to be unnecessary or unsatisfactory, and in view of the most discouraging results of fixing times and places at which persons in need of help might consult the psychiatric social workers, a different method of approaching the problem has been considered."

The revised scheme is as follows:—

- (1) The psychiatric social workers on the staff of the mental hospitals will no longer be made use of by the county council.
- (2) The area welfare officers' services will be relied on to:—  
(a) Help persons who might, under adverse circum-

stances were relieved, become mental patients;

(b) Advise and persuade those who appear to need psychiatric treatment to consult their own doctor or, if they do not wish to do so, at any rate see the psychiatrist;

(c) With the consent of the person's doctor, help such patients to attend the psychiatrist and, if need be, personally convey them.

(3) The area welfare officer will attend the psychiatric clinic at the first attendance of any new cases with which he has been concerned, to give what information and help he can to the psychiatrist. He will not attend as a routine.

(4) The area welfare officers' offices to be the place at which all contact should be made between the area welfare officer and persons needing help, or where doctor or psychiatric social worker may request assistance and information.

This scheme came into effect on April 1st, 1950.

Area welfare officers have been asked to pay particular attention to the following points:—

(1) It is important that all persons who appear to need psychiatric advice should be urged to consult their own doctor, and only if they definitely refuse to do so will the area welfare officer act on his own responsibility.

(2) No person should be referred to the psychiatrist without an appointment. This appointment should normally be made by the patient's own doctor, and only by his request, or if the patient definitely refuses to consult his doctor, will the area welfare officer make the appointment himself.

(3) The area welfare officer will inform the general practitioner of any patient whom he has advised to consult him, so that he (the A.W.O.) may assist the practitioner in any way in his power. He should ask that he may be informed by the doctor of any appointment made to see the psychiatrist so that he may attend, to offer any help he can to the psychiatrist.

During the month this new scheme has been operating the area welfare officers have dealt with 14 cases, four men, eight women and two children, of whom six were referred by their own doctors to the area welfare officers, five were referred by the area welfare officers to their doctors, two were referred directly to the psychiatrist and one refused advice.

The psychiatrists are unanimous in their approval of the co-operation and help given by the area welfare officers. The amount of preventive work done by the area welfare officers is naturally very difficult to assess since it is hoped that a good deal of their routine duties will by relieving causes of anxiety prevent mental breakdown.

## SOCIETY OF MEDICAL OFFICERS OF HEALTH

### NOTICES ORDINARY MEETING

Notice is hereby given that an Ordinary Meeting of the Society will be held at Tavistock House, London, W.C.1, on Thursday, October 19th, 1950, at 5.30 p.m. The retiring President (Dr. H. C. Maurice Williams) will induct the President-elect (Dr. J. M. Gibson) and the latter will deliver his Presidential Address. Full agenda, including the names of candidates for election at this meeting, will appear in the October issue of *Public Health*.

By Order,  
Tavistock House,  
W.C.1.  
G. L. C. ELLISTON,  
*Executive Secretary.*

### THE ANNUAL DINNER

The Annual Dinner of the Society will be held on Thursday evening, November 23rd next, at the Piccadilly Hotel, W.1, with the President for the session 1950-51 (Dr. J. M. Gibson) in the chair. The principal guest will be the Chief Medical Officer, Sir John Charles. Tickets will cost 22s. 6d. (inclusive of coffee and gratuities but not of wines and smokes). Applications with remittances should be made as early as possible to the Executive Secretary of the Society, Tavistock House, Tavistock Square, London, W.C.1.

### DENTAL OFFICERS' METROPOLITAN AND HOME COUNTIES SUB-GROUP

The Annual General Meeting will be held in the Hastings Hall, Tavistock House, W.C.1, on Friday, September 29th, 1950, at 7.30 p.m. After elections for 1950-51, Mr. D. C. O'Regan, L.D.S., will speak on "Treatment of Injured Teeth in Children."

<sup>†</sup> See "One Approach to Mental Preventive Medicine," F. J. G. Lishman. *Public Health* (July, 1949), 62, 210. "Preventive Mental Health Advisory Scheme," J. L. Farmer. *Ibid.* (July, 1949), 62, 212.

## ORDINARY MEETING

An ordinary meeting of the Society was held on Friday, July 7th, 1950, at the Polygon Hotel, Southampton, on the occasion of the dinner given by the Southern Branch to the Council. After the loyal toast had been honoured, the chairman of the dinner (Dr. A. A. Lisyne, President, Southern Branch) vacated the chair in favour of the President of the Society (Dr. H. C. Maurice Williams, O.B.E.). Twenty-five members of the Council and 43 other members and their ladies attended.

The President began by explaining why it had been arranged to constitute this gathering of members and guests as an ordinary meeting of the Society to transact an important item of business, viz., the election of Sir Wilson Jameson as an Honorary Fellow for which the Articles of Association required that the name and address of the nominee be inserted in the notice convening the meeting where the election was to take place. This dinner had been the first opportunity of bringing forward the recommendation of the officers and of the Council, unanimously decided at its last meeting on May 19th.

"It is my privilege and pleasure this evening," continued Dr. Williams, "to propose the election of Sir Wilson Jameson as an Honorary Fellow of the Society of Medical Officers of Health. I do not think there is a college, an institution or a society that takes greater care in the selection of those deemed worthy of this distinction.

"When the Council heard of the impending retirement of Sir Wilson as Chief Medical Officer to the Ministry of Health in May of this year they were anxious, as representing public health services of the country, to offer Sir Wilson the highest distinction it was possible for them to offer, in recognition of his outstanding work in the realms of public health.

"During his distinguished career Sir Wilson has received some of the highest national honours; he has been created a Knight Grand Cross of the Order of the British Empire; a Knight Commander of the Order of the Bath; he has had conferred upon him Doctorates in Laws, Science and Hygiene from the principal universities of this country and Canada; he has been elected to the Fellowships of the three Royal Colleges, and yet I venture to think that his election as an Honorary Fellow of his own Society will give him as much if not greater personal pleasure because it illustrates the esteem in which he is held by his colleagues in the branch of medicine which he himself chose to take up.

Dr. Williams said that he had been brief because he wished to call on Sir Allen Daley to second, and Dr. James Fenton and Prof. R. H. Parry to support this proposal.

Sir Allen Daley, seconding the proposition, gave a comprehensive review of the career of Sir Wilson as public health officer, teacher and administrator culminating in his period of office at the Ministry of Health during the stern trials of war and the inauguration of the National Health Service. His achievement in maintaining the health of the people during the war had been recognised at home and abroad; in the U.S.A., for instance, he had been the joint recipient, with Lord Woolton and Sir Jack Drummond, of the Lasker Award, made through the American Public Health Association. Sir Allen emphasised the care with which the Society selected names for addition to its small and distinguished company of Honorary Fellows: Sir Wilson had been adjudged as completely qualified on the strict criteria applied for British nominees. Lastly, from his personal knowledge of recent history, he affirmed the efforts which Sir Wilson had made to get prevention given a more prominent part in the Act of 1946.

Dr. Fenton, supporting the proposal, spoke as one who had known Sir Wilson for many years, first as a fellow M.O.H. and latterly as a medical officer on his staff at the Ministry. He had always been impressed by his broad outlook and equable temperament, and recently by his accessibility as C.M.O. and by the obvious regard and affection in which he was held by his staff.

Prof. Parry, another very old friend, supported the motion with enthusiasm as a fellow Celt.

The President then put the proposition to the meeting that Sir William Wilson Jameson, G.B.E., K.C.B., M.A., M.D., F.R.C.P., F.R.C.O.G., F.R.D., D.P.H., of 8, Fordington Road, Highgate, London, N.6, be elected as Honorary Fellow of the Society. This was carried unanimously with acclamation, and he was declared elected and given an inscribed certificate.

Sir Wilson Jameson, in a modest and charming reply, disclaimed any special merit to the achievement of the high posts he had held, but ascribed them to his luck in always being in the right place at the right time. This applied particularly to the circumstance that he became Medical Adviser to the Colonial Office when Mr. Malcolm Macdonald was Secretary for the Colonies, and to his transfer to the Ministry of Health when

the latter became Minister. He had throughout his career retained the outlook gained in his years as an M.O.H. Two of the occasions since his retirement would have particular places in his memories. One was the dinner given to him and his old colleague, Brig. G. S. Parkinson, by their past students of the London School of Hygiene and Tropical Medicine. The other was this delightful evening with his brothers in the public health service and the Society. He finished with a reaffirmation of his confidence in the public health service as a career.

Dr. Williams then returned the chair to Dr. Lisyne, who graciously proposed the toast of the Council of the Society, saying how great a pleasure it was for branch members to meet members of the Council whose names and reputations were already so familiar to them. The reply was made in a witty speech by the President-elect of the Society (Dr. J. M. Gibson), who expressed the warm thanks of the Council for the magnificent hospitality of the Branch.

Between the Council meeting in the afternoon and the dinner the President and Mrs. Williams gave a delightful reception to members of the Council and officers of the Southern Branch at their house on the outskirts of Southampton.

## COUNCIL MEETING

A meeting of the Council of the Society was held in the Pilgrim Room, Polygon Hotel, Southampton, on Friday, July 7th, at 2.30 p.m.

102. The Chairman of Council (Sir Allen Daley) presided and there were also present the President (Dr. H. C. Maurice Williams), Drs. W. Alcock, C. Fraser Brockington, C. Metcalfe Brown, J. S. G. Burnett, George Chesney, James Fenton, Miriam Florentin, J. M. Gibson, Kathleen M. Hart, A. S. Hebbethwaite, C. E. Herington, G. Hamilton Hogben, Sir Wilson Jameson, Prof. J. Johnstone Jervis, Drs. R. H. H. Jolly, J. Maddison, G. A. W. Neill, Prof. R. H. Parry, Drs. R. C. M. Pearson, T. Ruddock-West, J. A. Struthers, Mr. A. Gordon Taylor, I.D.S., Drs. W. S. Walton, Norah I. Wattie, Ann Mower White and J. Greenwood Wilson.

103. *Apologies for Absence* were received from: Dr. H. D. Barker, Mr. J. V. Bingay, I.D.S., Drs. George Buchan, H. D. Chalke, W. G. Clark, H. M. Cohen, C. K. Cullen, F. M. Day, R. H. G. Hector Denham, Sir George Elliston, Prof. W. M. Frazer, Drs. G. M. Frizelle, F. Gray, F. Hall, J. A. Ireland, Prof. J. M. Mackintosh, Drs. Maurice Mitman, A. A. E. Newth, F. R. O'Shie, Wyndham Parker, A. Morrison, Hugh Paul, J. Ridell, J. A. Stirling, G. McKim Thomas and A. L. Taylor.

104. *Honours to Members*.—The Chairman, Sir Allen Daley, announced the following appointments as Honorary Physicians to His Majesty the King from July 1st for three years and expressed on behalf of the Council the congratulations of the Society to the members concerned: Dr. S. Barron (M.O.H., Belfast), Dr. A. Massey (Chief M.O., Ministry of National Insurance), Prof. R. H. Parry (M.O.H., Bristol), and Dr. H. J. Rae (M.O.H., Aberdeen).

105. *Minutes of the Meeting held on May 19th, 1950 (Public Health)*, pages 198-200) were confirmed and signed.

106. *Rubella (Min. 93)*.—The Executive Secretary reported that the circular letter, a draft of which was before the last meeting, had been sent to M.O.H.s of all county councils and county boroughs. Favourable replies had been received from 56 county councils and 77 county boroughs.

107. *Whitley Medical Functional Council*.—Dr. C. Metcalfe Brown submitted a report of the present position in the negotiations on salaries and conditions of service in Committee C of the Whitley Medical Functional Council.

The attention of the Committee was drawn to recent agreements on salary scales for public health nurses that additional amounts to the Rushcliffe and Guthrie scales should be paid to public health nurses with retrospective effect to February 1st, 1949.

108. *Dental Whitley Functional Council*.—Mr. A. Gordon Taylor submitted a verbal report on negotiations for dental officers' salaries which were taking place in the Dental Whitley Council.

109. *Employment of Dental Practitioners*.—It was reported that a recent circular sent out by the B.D.A. to advise general dental practitioners in the National Health Service to devote part of their time to the treatment of priority classes had an unfavourable reception. It was felt that, for any such scheme to be successful, the general practitioners should be asked to attend sessions for the priority classes at local health authority clinics.

110. *British Medical Guild*.—It was reported that the Public Health Committee of the B.M.A. had now approved the Trust Deed for the Public Health Defence Trust. It had been decided not to limit the applicability of the Trust to practitioners em-

ployed whole time in the service and the reference to whole-time officers had been deleted from the deed. The rate of contribution had been agreed at 2s. per £100 of remuneration and would be collected centrally by officers of the British Medical Guild.

111. *Foot Health Exhibition*.—It was reported that the meeting arranged by the M. & C.W. Group during the National Foot Health Exhibition had been held and was addressed by Mr. Denis Browne (Surgeon, Hospital for Sick Children, Great Ormond Street) on the types of foot conditions in children requiring orthopaedic advice. The meeting had been attended by approximately 70 members of the Society.

112. *Royal Sanitary Institute and Sanitary Inspectors Examination Joint Board* (*Min. 81*).—It was reported that Dr. C. Herrington now found that meetings of the Examination Joint Board were always held on a day when it was impossible for him to attend. It was resolved that Dr. J. S. G. Burnett be appointed in his stead.

113. *Committee on Internal Administration of Hospitals*.—It was reported that Dr. Maurice Mitman was preparing a draft memorandum for consideration by the Committee. The Society's previous memorandum on Medical Administration had been presented to the B.M.A. Consultants and Specialists Committee by Dr. C. Metcalfe Brown. The Consultants and Specialists had appointed a special sub-committee with added representatives from the Public Health Committee, the medico-psychological bodies and the Medical Superintendents Society to prepare a joint document for presentation, but after consideration, it was resolved that the Society should prepare an independent report, and the B.M.A.'s agreement be obtained to its submission direct to the C.H.S.C. Committee.

114. *Royal Sanitary Association of Scotland*.—The President informed the Council that the date of the annual conference of the Royal Sanitary Association of Scotland clashed with that of the Sanitary Inspectors' conference at Bridlington at which he intended to be present. It was resolved that Dr. J. M. Gibson, the President-elect, attend the conference of the Royal Sanitary Association of Scotland.

115. *Vaccination*.—The following resolution from the Yorkshire Branch was received:—

"The Yorkshire Branch considers that the problem of vaccination requires urgent consideration, if a good herd immunity equivalent to that in diphtheria is desired. This cannot be achieved until the prevailing attitude of the public generally has been altered by a national campaign.

"It is urged that the Society should consider the problem in all its aspects so as to give a lead to medical officers of health on the subject, and, if considered necessary, request the Ministry of Health to undertake national propaganda on the subject."

It was unanimously resolved that the following be appointed a committee to conduct an enquiry as to whether the Society should advocate mass infantile vaccination and as to the efficacy of the present technique of vaccination: the President (Dr. H. C. Maurice Williams), the Chairman of Council (Sir Allen Daley), the President-elect (Dr. J. M. Gibson), the Chairman of the General Purposes Committee (when elected), Drs. Stuart Laidlaw, Maurice Mitman, W. H. Bradley, M. T. Morgan, C. Metcalfe Brown and W. Alcock.

116. *Hygiene in Hotel Kitchens*.—The following letter was received from a Fellow of the Society:—

"I have recently been interested to observe in the new book of approved hotels for 1950 published by the Automobile Association, that a certain hotel in this City was classified as a four-star hotel, meaning that it is a luxurious hotel providing a high standard of comfort and modern amenities. It happened that I recently had occasion to inspect this hotel and, while I quite agree with the classification so far as the public rooms are concerned, I found that the kitchen quarters were far from satisfactory.

"If this is an example of the meaning of this classification by the A.A. and other motoring and travel organisations, I suggest that in the interests of our campaign against food poisoning, and to promote hygiene in the kitchen, the A.A., R.A.C., and other bodies of a similar nature might be of great assistance. I have suggested to the A.A. that the inspection of hotels for the purpose of classification should be carried out by somebody qualified in modern hygiene or, conversely, that a classification might be obtained from the local medical officer of health.

"I quite see that there are great difficulties in this matter, but the help which motoring bodies might give to the cause of hygiene appears to me to be very great. I would like, therefore, to suggest that the Council might consider a conference with the motoring and travel organisations, possibly with the co-operation of the Ministry of Health, in order to establish a satisfactory method of inspection and to arrange a code of classification of

hotels and restaurants which would convey to the travelling public some indication that the hygiene in any place was up to a certain standard. I would be quite willing to co-operate with the A.A. so far as local hotels are concerned, but suggest that this is a national matter for consideration by the Society."

After discussion it was resolved that although the Council agreed with the sentiments expressed in the letter it was not considered expedient to take any action in view of the probable legal difficulties.

117. *New South Wales Branch*.—Mr. A. Gordon Taylor, who had recently visited Australia, and, during the course of his visit, had had a discussion with Dr. J. Drew, the President, and Dr. Cooper Booth, the Secretary of the New South Wales Branch, submitted a report on that Branch. It was resolved that the Society do everything it possibly could to support the Branch and the Editor of *Public Health* was requested to prepare an editorial for a future issue of *Public Health* to that end. The Executive Secretary stated that he would discuss the question with the Secretary of the B.M.A. to see if some means of encouragement could be given through the B.M.A. in Australia.

118. *Meat Inspection*.—It was reported that a letter dated June 6th had been received from the Ministry of Food stating that the Interdepartmental Committee on Meat Inspection was anxious to obtain information regarding the numbers and qualifications of those engaged in meat inspection. It was proposed to send a questionnaire to all local authorities for completion and the suggested questionnaire was forwarded for comments of the Society. The enquiry had been passed on to the Standing Subcommittee for Food Matters and the Ministry of Food had been informed that there were no comments that the Society wished to make.

119. *General Nursing Council*.—A letter dated June 7th was received from the Ministry of Health inviting the Society to make suggestions as to the persons to be appointed to the General Nursing Council under the following headings:—

(a) Two registered nurses employed in services provided under Part III of the National Health Service Act, 1946, i.e., local health authority services.

(e) Three persons having had experience in the control and management of hospitals.

It was resolved that the following names be submitted under paragraph (a) provided the persons concerned were willing to allow their names to go forward: Miss Calder, L.C.C., and Miss Davies, Cardiff, or failing them Miss Owen, Oxfordshire, and Miss Robinson, Lancashire. It was resolved also that under paragraph (e) the following names be submitted: Dr. C. Fraser Brockington, Prof. W. M. Frazer and Prof. I. G. Davies. The Executive Secretary was instructed to inform the Minister that the Society hoped that his nominations would result in more adequate representation of nurses from non-teaching hospitals where the main problems of nursing were to be found.

120. *Civil Defence*.—A letter dated June 15th was received from the Ministry of Health inviting the nomination of a C.B. and a county M.O.H. to attend the course for S.A.M.O.s of Regional Boards to be held at the Sunninghill Civil Defence Staff College from July 24th to 28th.

It was resolved that Dr. W. S. Walton and Dr. C. Fraser Brockington be asked to attend the course. It was resolved further that the Ministry be asked if there was any intention to arrange a course on civil defence for M.O.H.s of local authorities.

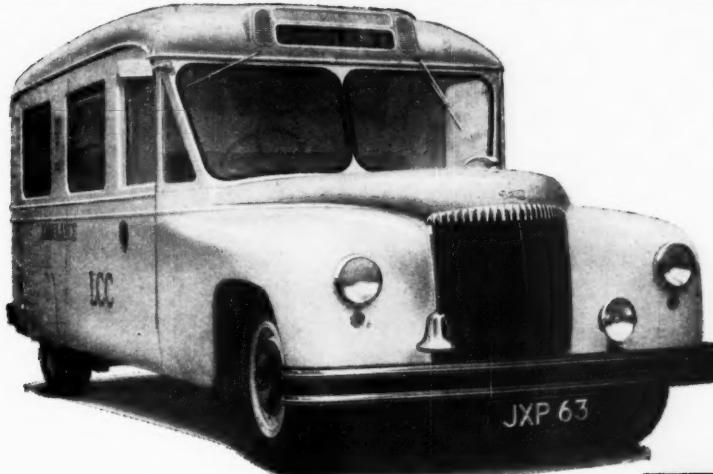
121. *Statutory Limits for Fish Paste*.—A letter dated June 17th from the Ministry of Food requested the Society's observations on the Food Standards Committee's recommendations for Statutory Standards for fish paste. The enquiry had been referred to the standing sub-committee for food matters for consideration.

122. *Survey of Child Development*.—The County Borough Group of the Society had recently considered the survey of child development following the maternity services enquiry conducted by the R.C.O.G. Population Investigation Committee and the London Institute of Child Health. The following is the minute of the discussion:—

"The meeting discussed the matter at length and a resolution was proposed by Dr. Hughes that the County Borough Group desired to draw the attention of the Council of the Society to the growing practice of outside bodies to use detailed statistical information drawn from health departments (and involving a considerable amount of work) without proper and adequate reference and acknowledgement to the Society. The meeting left it in the hands of the Council to decide upon an appropriate approach to such bodies if the Council upheld this suggestion of the County Borough Group."

(Continued on page 238)

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It was agreed that the Society should be represented on the organising committees of such enquiries or surveys where the field work was done by health departments. With reference to the recently announced survey on Growth of Infants and Young Children under the Ministry of Health and Education and the British Paediatric Association, it was resolved to ask the C.M.O. to add two representatives of the Society to the organising committee and to ask the School Health Service and M. & C.W. Groups to suggest suitable names. It was also resolved that bodies conducting investigations should be informed that the Society, as such, would like to be associated with all enquiries where the bulk of the work was carried out by staffs of health departments. A further resolution was accepted that consideration be given by the General Purposes Committee to the suggestion that the Society should itself initiate investigations and research projects.

123. *Relations of the Society and the Association of Municipal Corporations.*—At a recent meeting of the County Borough Group, Dr. Irvine (Dewsbury) drew attention to the fact that the views of borough M.O.H.s were not presented to the Association of Municipal Corporations in the same way as are those of county council M.O.H.s to the County Councils Association. After considerable discussion by the Group it had been resolved to press the Council of the Society to ask the A.M.C. to consider ways and means of getting the official advice of the Society on public health problems, and to ask the Chairman of the Public Health Committee of the Association of Municipal Corporations to receive a deputation from the Society on this matter. Dr. A. A. E. Newth, who was unable to be present at the meeting, expressed his views on the parallel question of the Association of Education Committees in a letter which was read. The question was referred to the General Purposes Committee for consideration.

124. *Functions of Medical Officers of Health.*—The Executive Secretary reminded the Council that all Branches and the County, County Borough and County District Groups had been asked to consider the preparation of a list of duties which they consider should be allocated to the M.O.H. of local health authorities. Several of the Branches had now forwarded their recommendations. It was resolved that the following be appointed to the Committee to consider the recommendations from Branches and to submit a report to Council: the President (Dr. H. C. Maurice Williams), the President-elect (Dr. J. M. Gibson), the Chairman of Council (Sir Allen Daley), Prof. R. H. Parry, Drs. F. Hall, J. A. Stirling, F. M. Day, W. E. Thomas, G. W. H. Townsend or substitute, Dr. N. Gebbie and Dr. W. S. Walton together with one representative each from the M. & C.W. and School Health Service Groups, or deputies to be appointed by them.

125. *Nominations for Life Membership.*—The following recommendations for life membership from the following Branches were confirmed for presentation at the next ordinary meeting of the Society:—

*Home Counties Branch:* Dr. G. R. Bruce, formerly M.O.H., Hastings C.B. (1919); Dr. T. Farthing, formerly M.O.H., Dartford U.D. (1922); Dr. J. Ramsbottom, formerly Assistant C.M.O.H., Essex C.C. (1920); Dr. C. C. Pickup, formerly M.O.H., Wombwell C.C. (1921); Dr. Rachel H. Shelley, formerly Assistant M.O.H., Middlesex E.C. (1920); Dr. Donald MacIntyre, M.C., formerly Med. Supt., Plaistow Fever Hospital (1922);

*Metropolitan Branch:* Dr. Louisa C. Adam, formerly Assistant M.O., L.C.C. (1923).

*Northern Branch:* Dr. W. H. Dickinson, formerly Consulting Chest Phys., Newcastle-upon-Tyne (1913).

*Scottish Branch:* Sir Alexander S. M. Macgregor, formerly M.O.H., City of Glasgow (1924); Dr. C. A. Bignold, formerly M.O.H., Ayrshire C. (1912); Dr. J. H. Hunter, formerly Chief Chest Phys., Dundee (1919); Dr. A. D. Cowan, formerly S.M.O., Dunbartonshire (1916).

#### 126. *Representation of the Society.*

(a) *General Council for the National Registration of Plumbers.*—Dr. A. R. Miller (Senior A.M.O., City of Glasgow) had attended the annual meeting of the above in Glasgow on June 28th on the Society's behalf and had expressed to the meeting the goodwill of the Society. It was resolved that Dr. Miller be thanked for attending the meeting.

(b) It was resolved that the following members be appointed to represent the Society at the conferences mentioned:—

(1) *Conference on Food and Drink Infections* (Sponsored by the C.C.H.E.) at Olympia on August 31st, Dr. H. C. Maurice Williams.

(2) *Central Council for Rivers Protection.*—The conference to discuss:—

(i) The report of the Rivers Pollution Prevention Subcommittee of the Central Advisory Water Committee, 1949, and the steps that should be taken to obtain a new anti-pollution law.

(ii) The hydro-electric schemes of the British Electricity Authority for North Wales.

Two representatives: Col. E. F. W. Mackenzie and Dr. George Chesney.

(3) *National Safety Congress.*—Dr. John Maddison, October 16th to 18th, Central Hall, Westminster.

127. *Refresher Course.*—It was resolved that all Groups be asked to consider the dates of any proposed course to be held during the session 1950-51 in order that a circular could be sent to all local authorities giving advance information of all courses to be sponsored by the Society. The Executive Secretary reported that Prof. F. Grundy had proposed to run a five-day course at the Welsh National School of Medicine, Cardiff, probably in December, for M.O.H.s who are desirous of conducting researches and surveys in their areas and who were unassociated with university departments of preventive medicine. It was resolved that Prof. Grundy be told that the Society would be very glad if he would arrange the course proposed.

128. *Local Government Manpower.*—Attention of the Council was drawn to the editorial in the April issue of *The Sanitarian*.

129. *Medical Inspection of Teachers and Intending Teachers.*—The following letter dated July 3rd was received from Dr. J. E. Underwood, Ministry of Education:—

"Some time during the first half of 1947 we submitted to your Society a memorandum (our reference R.528/19) on the medical examination of teachers and intending teachers. Briefly, the proposals were to place on local education authorities the responsibility of arranging for the medical examination of students entering training colleges and of a certain number of teachers taking up appointments, by school medical officers. The memorandum was submitted to the School Health Service Group and generally speaking their reactions were favourable. In view of the uncertainty with regard to the operation of the National Health Service Act and for other reasons, the scheme was dropped at that time. It is now being reconsidered. As it is some time since the matter was considered by your Society, and as circumstances may have changed considerably since 1947, I should be very grateful if you could let me have the present views of your Society, particularly on (a) whether the scheme has advantages over the present system, and (b) whether, in view of the medical staffing position, it would be practicable for local education authorities to operate it." [The number of entrants were approximately: to the training colleges or university departments, 10,650; to the teaching profession, 2,200.]

It was felt that the Society should agree in principle to the suggestions contained in the letter but that the matter should be referred to the School Health Service Group.

130. *Control of Major Epidemic Diseases.*—A letter dated July 4th was received from the Ministry of Health enclosing a draft memorandum proposed to be sent by the Ministry of Health to R.H.B.s, H.M.C.s and B.G.s and for information to all local authorities. It was resolved that subject to the amendment of the heading of the document to the words "Control of Communicable Diseases" and to consequent amendments in the body of the document and to a general affirmation of the position of the M.O.H. as local consultant in communicable diseases the Ministry be informed that the Society was in agreement with the document.

131. *Subsistence Expenses for Members of Committee C.*—Dr. C. Metcalfe Brown raised the question of the subsistence expenses paid by the Society for members of Committee C who require it in view of the fact that the British Medical Association paid the necessary train fares but no subsistence allowance. The Honorary Treasurer was asked to submit a report of the possible amount involved to the next meeting of the General Purposes Committee.

132. *International Public Health Association.*—A letter dated July 6th from Prof. René Sand was received. The letter referred to the recent enquiry as to whether the Society would be willing to co-operate in the formation of an International Public Health Association and stated that many countries had expressed a desire to participate. The Society was asked to send a representative to attend the International Public Health conference to be held in Paris on October 23rd and 24th to discuss the matter further.

The President and Chairman of Council were asked to give further sympathetic consideration to these proposals and to advise the Society on the proper course to adopt.

There being no other business the meeting terminated at 5 p.m.



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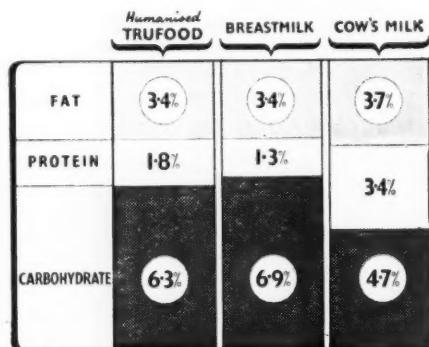
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